SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Spravato® (esketamine) (S0013)

Mark the benefit you would like the PA entered under:

- ❑ Pharmacy Benefit
- ❑ Medical Buy and Bill – submit prior authorization request via fax to pharmacy **1-844-305-2331**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit:

- Major Depressive Disorder with Acute Suicidal Ideation or Behavior: 8 kits/month; 1 month of treatment
- Treatment-Resistant Depression: 4 kits/month (*induction dose requires 8 kits/month)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. Check box below for the Diagnosis that applies.

Choose **ONE** of the following applicable diagnoses below**. Provider Please Note:** Any indication that is **NOT** FDA approved will be considered experimental/investigational and **NOT** medically necessary

(Continued on next page)

❑ **Treatment Resistant Depression. ALL the following criteria must be met:**

Reauthorization is NOT required

- ❑ Member must be 18 years of age or older
- ❑ Spravato® must be prescribed by **ONE** of the following:
  - ❑ Psychiatrist
  - ❑ Provider who has consulted with a psychiatrist (include name/date): _____
- ❑ Member must have a diagnosis of treatment resistant depression (TRD) without psychotic features defined by current DSM criteria made or verified by a psychiatrist
  - ❑ **ICD Code/Diagnosis:** _____
- ❑ Member must be experiencing moderate to severe symptomology documented by a standardized rating scale that reliably measures depressive symptoms. **A current baseline (within previous 30 days, prior to starting Spravato®) scale with scoring must be attached.**
  - ❑ **Scale:** _____
  - ❑ **Date Administered:** _____
- ❑ Member must have experienced clinical failure or intolerance with at least two (2) antidepressant therapies from at least two (2) different drug classes **(verified by pharmacy paid claims and/or chart notes)**
  - Failures must be of adequate dose (maximally tolerated)
  - Failures must be of adequate duration (at least 6 weeks)
  - Adherent fills required (verified by pharmacy claims)
  - Failures must occur during current depressive episode
  - Antidepressant therapy would include any of the following classes:
    - Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
    - Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine)
    - Bupropion
    - Tricyclic antidepressants (e.g., amitriptyline, clomipramine, nortriptyline)
    - Mirtazapine
    - Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine)
    - Serotonin modulators (e.g., nefazodone, trazodone)

1. **Drug:** _____ **Dose:** _____ **Duration:** _____
   Reason for Discontinuation: _____
2. **Drug:** _____ **Dose:** _____ **Duration:** _____
   Reason for Discontinuation: _____

(Continued on next page)

- ❑ Member must have experienced clinical failure or intolerance with at least one (1) augmentation therapy (e.g., lithium, liothyronine, antipsychotics or anticonvulsants) **(verified by pharmacy paid claims and/or chart notes)**
  - Failures must be of adequate dose (maximally tolerated)
  - Failures must be of adequate duration (at least 6 weeks)
  - Adherent fills required (verified by pharmacy claims)
  - Failures must occur during current depressive episode

  1. **Drug:** _____ **Dose:** _____ **Duration:** _____

     Reason for Discontinuation: _____

  2. **Drug:** _____ **Dose:** _____ **Duration:** _____

     Reason for Discontinuation: _____

- ❑ Member does **NOT** have aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels), arteriovenous malformation, or a history of intracerebral hemorrhage
- ❑ Prescriber must have assessed the member's risk for abuse of controlled substances (i.e., review of medical history, review of state prescription monitoring program (PMP))
- ❑ Member must be enrolled in the Spravato® REMS program
- ❑ Administering site/provider must be certified in the Spravato® REMS program:
  - ❑ **Name/Location of Administering Provider:** _____

❑ **Diagnosis: Major Depressive Disorder with Suicidal Ideation or Behavior**
❑ **Continuation of inpatient Spravato® therapy, ALL the following criteria must be met:**
One-time authorization per episode for remaining doses required for continuation. Maximum allowable duration = 1 month

- ❑ Provider **MUST** submit date of therapy initiation and number of doses administered up to point of request
  - ❑ **Date Spravato® therapy initiated:** _____
  - ❑ **Number of doses administered since initiation:** _____
- ❑ Member must be 18 years of age or older

(Continued on next page)

❑ **Diagnosis: Major Depressive Disorder with Suicidal Ideation or Behavior**
❑ **Initiation of outpatient Spravato® therapy, ALL the following criteria must be met:**
One-time authorization per episode for a duration of 1 month, total of 8 kits/month

- ❑ Member must be 18 years of age or older
- ❑ Spravato® must be prescribed by or in consultation with a psychiatrist
  - ❑ Psychiatrist
  - ❑ Provider who has consulted with a psychiatrist (include name/date): _____
- ❑ Member must have a diagnosis of major depressive disorder **with** acute suicidal ideation or behavior verified by a psychiatrist
- ❑ Spravato® must be used in combination with a daily oral antidepressant. **Documentation (pharmacy claims or chart notes) required.**
  - ❑ **Drug:** _____
- ❑ Prescriber must have assessed the member's risk for abuse of controlled substances (i.e., review of medical history, review of state prescription monitoring program (PMP))
- ❑ Member must be enrolled in the Spravato® REMS program
- ❑ Administering site/provider must be certified in the Spravato® REMS program:
  - ❑ **Name/Location of Administering Provider:** _____

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Proprium Rx**

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~9/19/2019; 11/19/2021; 9/26/2024;~~ **3/27/2025**
REVISED/UPDATED/REFORMATTED: ~~9/27/2019; 10/5/2019; 7/1/2020, 8/26/2020; 6/30/2021;7/26/2023; 10/4/2023, 10/15/2024; 4/15/2025;~~ **5/5/2025**